

Chronic Obstructive Pulmonary Disease (COPD) Treatment and Prevention of Readmission

Reviewed and approved by CHAC Clinical Committee on 02.17.2015

Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults.

Numerator:

Observed discharges from an acute care hospital with a principal diagnosis of COPD or Asthma for patients aged 40 years and older with a diagnosis of COPD or Asthma.

Denominator:

Expected discharges from an acute care hospital with a principal diagnosis of COPD or Asthma for patients aged 40 years and older with a diagnosis of COPD or Asthma.

Exclusions:

Admissions that are transfers from another hospital; skilled nursing facility; intermediate care facility; other health care facility; admissions associated with a diagnosis of Cystic Fibrosis or anomalies of the respiratory system; patients with a diagnosis of ESRD.

Source: claims data

What is the problem and what is known about it so far?

According to 2013 data from Vermont Behavioral Risk Factor Surveillance Survey, 6% of Vermont adults have been told that they have Chronic Obstructive Pulmonary Disease (COPD). As its name suggests, COPD is a chronic, incurable and progressive illness characterized by multi-morbidity, frequent exacerbations with subsequent loss of function and quality of life experience. Associated social, health and financial costs are high. The management of COPD is a notable challenge for patients, clinicians and health systems. Advanced disease management necessitates a directed, coordinated and collaborative effort between stakeholders who hold a common understanding of available resource and clinical goals.

Recommendations for Provider Teams:

A: Diagnosis and Classification

Recommendation	Action	Collaboration/CHAC Approach
<i>Diagnosis</i>	<ul style="list-style-type: none"> • Patient suspected with COPD (cough, sputum, dyspnea) will have airflow assessment using Spirometry. • Patients with COPD will undergo Spirometric testing every two years to validate and reclassify disease severity; alternatively within six months of an indexed clinical event. • Complete H&P should be performed to verify: <ul style="list-style-type: none"> a) Tobacco Status 	<ul style="list-style-type: none"> • Identify cohort population • Risk stratify individual patients • Schedule periodic ambulatory assessment encounters. • Educate patients/families. • Develop a COPD Self-Management and Action Plan.

	b) Co-Morbid Conditions c) Exercise Tolerance d) Health Status	
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B: Disease Management

<i>Recommendation</i>	<i>Action</i>	<i>Collaboration/CHAC Approach</i>
<i>Step care for clinical need and disease severity</i>	<ul style="list-style-type: none"> Inhaled bronchodilators. Long-acting muscarinic antagonist (LAMA) recommended for risk reduction of exacerbation and to improve symptoms. Long-acting bronchodilators (LAMA and/or long-acting beta agonist-LABA) for symptom relief in moderate to severe COPD. Combination therapy for moderate to very severe COPD (LAMA and/or LABA) plus an inhaled corticosteroid (ICS). For very severe COPD and frequent exacerbation, add inhaled corticosteroid. Antibiotics and systemic corticosteroid for treatment of exacerbation. Long-term systemic corticosteroids (> one month) not recommended. Identify and treat co-morbidities independently. Long-term macrolide antibiotics, ER theophylline, N-acetylcysteine and roflumilast are therapeutic options for selected patients with severe disease. 	<ul style="list-style-type: none"> Educate patient/family. Develop an individualized COPD Self-Management and Action Plan. Develop and implement a chronic care (COPD) checklist. Risk stratification is protocolled. Clinical risk reduction is structured into workflow. Functional and durable Direct Access to clinical care is fundamental to managing patients with COPD. Access will be structured at the facility and systems level of responsibility. Individualized Home or Rescue Kits can be a management consideration for selected and particularly vulnerable patients. Refer homebound pts to Home Health

C: Health Maintenance and Prevention

<i>Recommendation</i>	<i>Action</i>	<i>Collaboration/CHAC Approach</i>
<i>Immunizations</i>	<ul style="list-style-type: none"> Provide influenza vaccine annually to all patients with COPD or who smoke. Provide PCV-23 to all patients with COPD or who smoke. 	<ul style="list-style-type: none"> Educate patient/family Implement COPD Self-Management and Action Plan. Assess immunization status at <u>every clinical encounter</u>. Host flu shot clinics.
<i>Pulmonary Rehabilitation</i> <ul style="list-style-type: none"> Improves symptoms Improves activity capacity and quality of life experience 	<ul style="list-style-type: none"> Offered to every patient with COPD who would likely benefit. Target patients with a recent AECOPD. 	<ul style="list-style-type: none"> Educate patient/family to benefits of exercise and lifestyle modification. Refer homebound pts to Home Health

<i>Tobacco Cessation</i> Single most important intervention to modify risk for COPD related clinical events and co-morbidity	<ul style="list-style-type: none"> • Inquiry at every clinical encounter. • Medical intervention offered at every clinical encounter. 	<ul style="list-style-type: none"> • Patient/family education. • Refer to Vermont Quit Line and local resource. • Consider referral to Community Health Team (CHT).
<i>Self-Management Plan</i> Educate patient to the benefits of risk modification and emphasize importance of <u>early intervention</u> for <u>exacerbation</u>	<ul style="list-style-type: none"> • Develop and review a chronic disease Self-Management Program. 	<ul style="list-style-type: none"> • Implement/utilize COPD Action Plan • Ensure and test reliability for <u>Direct Access</u> at time of clinical need.

D: Transitions Management and Care Coordination

Care Transition is a vital, complex and multiple responsibility function. Patients with COPD are typically medically complex and multi-morbid, and therefore are best managed in a multi-disciplinary care environment which can be susceptible to fragmentation. This cohort is particularly vulnerable at the time of care transition and medical hand-off. Unstructured transitions can increase risks for avoidable suffering, unnecessary duplicity, medical error and higher costs. Effective communication across the continuum of care is fundamental to meeting Triple Aim goals.

Transition programming should be structured and powered to optimize patient and family experience within the context of a safe and high-quality care environment. To meet this goal, care at the time of transition should be organized with an understanding of the three domains of care coordination outlined by the National Quality Forum (NQF). These domains include:

- A Patient-Centered Care Plan which provides for the transfer of meaningful information such as clinical detail, medical record, reconciled problem and medication lists, and a plan of care; as well as sensibility for patient and family values, preferences, wishes and needs.
- Care plan execution within the context of a conceptual Health Neighborhood; for which primary care providers serve the important dual and parallel function of care coordination and medical oversight.
- Established clinical outcome goals.

E: Palliative Care

The decision to employ a Palliative Care consultation should be made from a Shared Decision perspective. The consultation should receive input from the patient, family, clinician(s) and other important stakeholders. Thresholds and triggers for palliation are invariably individualized. As a guiding principle, a Palliative Care consultation can be considered at the moment clinical management goals evolve from one of disease management and modification into a goal more oriented toward symptom management and optimization of life experiences.

Patient-level palliative programming should adopt a primary focus and sensibility for the quality of life of the individual patient, their caregivers and their family's experience. This work includes:

- Patient and family centered care with clarification of clinical understanding, acknowledgement of values and the expectations of care.

- Attention and management of symptoms which indicate suffering such as pain, dyspnea, anxiety, grief, delirium, weight loss, fatigue and serious bowel concerns.
- Implementation of a grief and bereavement management plan.

It is an expectation that patients enrolled in a Palliative Care Program to be managed within the framework of the six domains of quality health care outlined by the Institute of Medicine: safe, effective, timely, patient-centered, efficient and equitable care. Additionally, care for these patients should follow the general framework of palliative and end-of-life care domains (eight) forwarded by the National Quality Forum.

References and Tools:

Vermont Department of Health. *Vermont Behavioral Risk Factor Surveillance System 2013 Data Summary Report*, http://healthvermont.gov/research/brfss/documents/summary_brfss_2013.pdf, accessed 2/10/2015.

Global Strategy for the Diagnosis, Management and Prevention of COPD, <http://www.goldcopd.org>, accessed 2/19/2015.

National Quality Forum. *NQF Endorsed Measures on Care Coordination. December, 2014.* http://www.qualityforum.org/Publications/2014/12/NQF-Endorsed_Measures_for_Care_Coordination_Phase_3.aspx, accessed 2/10/2015.

National Quality Forum (NQF), *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*, Washington, DC: NQF; 2006, http://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_PREFERRED_Practices_for_Palliative_and_Hospice_Care_Quality.aspx, accessed 2/10/2015.

Criner GJ, Bourbeau J, Diekemper RL, et al. *Prevention of Acute Exacerbations of Chronic Obstructive Pulmonary Disease: American College of Chest Physicians and Canadian Thoracic Society Guideline.* Chest. 2014 Oct 16. doi: 10.1378/chest.14-1676.

Krames Patient Education. *Living Life to the Fullest with COPD.* <https://www.kramesstore.com>, accessed 2/10/2015.

The practices outlined in these recommendations are based on evidence-based guidelines and suggest one approach to caring for an individual with a diagnosis of COPD. We recognize that providers must exercise independent medical judgment in meeting the unique needs of each patient.

Hospital/Practice
Logo HERE

My COPD Action Log

Hospital Card Stamp if desired

Patient Name: _____ (first) _____ (last)

Doctor Name: _____

Date of Birth: ____/____/____ **or Medical Record #:** _____

Contact Information: () - -

My Action Log

[illegible]

Questions I need to remember to ask my provider:

Fall Risk Management

Reviewed and approved by CHAC Clinical Committee on 01.20.2015

Screening for Future Fall Risk

Numerator:

Documentation of the response to any of the following questions:

- Have you had any falls?
- 2 or more falls in the last year?
- Any fall with injury in the last year?

Does not have to be completed in the provider's office (i.e. PT, HH, telephonic visit)

Standardized falls risk screenings/assessments meet this measure if they ask about a history of falls

Denominator:

Age ≥ 65 with a visit during the measurement period (2014)

Exclusion:

Documented reason WHY patient is not at risk for falling
(e.g. patient not ambulatory)

Source: medical record review

What is the problem and what is known about it so far?

Falls are the leading cause of injuries in adults aged 65 and older. Nationally, one out of three adults in this age range will fall each year.ⁱ Data from 2012 indicated that in Vermont, a third of adults age 65 and older fell at least once during the year. During this same time frame, 4,500 adults age 65 and older reported falling four or more times. 34% of those adults that fell reported being injured.ⁱⁱ These falls result in a range of injuries from minor to severe, including lacerations, hip fractures, and head traumas. Risk of falls, including the fear of falling, limits mobility and independence. Adults age 75 and older who suffer a fall are four to five times more likely than those adults age 65 to 74 to be admitted to a long-term care facility as a result of that fall.ⁱⁱⁱ

Who should be screened?

All patients' age ≥ 65 during their Annual Exam

Recommendations for Provider Teams:

During the visit ask:

- have you been hospitalized since the last visit?
- have you fallen (or almost fallen) since the last visit?

Administer a Mobility Screening Test such as the Timed Up and Go (TUG) Test

If the results of the mobility screening are positive for falls risk:

- review medication (eliminate unnecessary medications, reduce doses of necessary medications to the lowest effective dose, reduce or eliminate the use of psychoactive drugs, medications that have anticholinergic side effects, and sedating over the counter medications such as Tylenol PM)
- review diagnosis

- ask about substance abuse

Follow-up care can include:

- Community Programs (e.g. balance classes; Bone Builders)
- order a VNA Home Safety Evaluation for patients who are essentially homebound.
- consider a physical therapy referral
- evaluate need for durable medical equipment (e.g. cane, walker)

Recommendations for Patients:

Action steps for patients at risk of falling should include:

- regular exercise (e.g.: Tai Chi)
- annual eye exams
- review of home for tripping hazards, need for grab bars, improved lighting, and railings on stairways
- screening for osteoporosis
- adequate intake of calcium and vitamin D

Resources and Tools:

STEADI (Stopping Elderly Accidents, Deaths & Injuries) Tool Kit for Health Care Providers:

<http://www.cdc.gov/homeandrecreationalsafety/Falls/steady/index.html>

STEADI Tool Kit: Instructional Videos for Health Care Providers:

<http://www.cdc.gov/homeandrecreationalsafety/Falls/steady/videos.html#TUG>

ⁱ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Falls Among Older Adults: An Overview*. Retrieved from <http://www.cdc.gov/homeandrecreationalsafety/Falls/adultfalls.html> on December 17, 2014.

ⁱⁱ Vermont Department of Health. *Behavioral Risk Factor Surveillance System Reports and Data Briefs*. Retrieved from <http://healthvermont.gov/research/brfss/reports.aspx#briefs> on December 17, 2014.

ⁱⁱⁱ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Falls Among Older Adults: An Overview*. Retrieved from <http://www.cdc.gov/homeandrecreationalsafety/Falls/adultfalls.html> on December 17, 2014.

The practices outlined in these recommendations are based on evidence-based guidelines and suggest one approach to caring for an individual at risk for falls. We recognize that providers must exercise independent medical judgment in meeting the unique needs of each patient.

Congestive Heart Failure (CHF)

Treatment and Prevention of Readmission

Reviewed and approved by CHAC Clinical Committee on 03.31.2015

Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Numerator:

Documentation of prescription for beta-blocker therapy during 2014

Can be documented in the OP medication list OR

Prescription or continuation of medication at discharge from inpatient stay

List of Beta-Blockers:

- Bisoprolol (Zebeta)

- Carvedilol (Coreg)

- SR Metoprolol Succinate (Toprol XL)

Denominator:

Patients > 18 diagnosed with HF with Left Ventricular Ejection Fraction < 40%

(LVEF results can be current or prior, meaning at any point in the patient's life)

Exclusions:

Medical reason: low BP, fluid overload, asthma, patients rx with an IV positive inotropic agent (eg. Digoxin, Gitalin, Lanatoside, beta-adrenoceptor agonists that increase the force and velocity of myocardial contractility), allergy, intolerance, or other documented medical reason.

Patient reason: patient declined or other patient reason

System: other reason attributed to the healthcare system

Source: medical record review

Ambulatory Sensitive Conditions Admissions: Heart Failure (HF)

Numerator:

Observed discharges from an acute care hospital with a principal diagnosis of HF for patients aged 18 years and older with a diagnosis of HF.

Denominator:

Expected discharges from an acute care hospital with a principal diagnosis of HF for patients aged 18 years and older with a diagnosis of HF.

Exclusions:

Admissions that are transfers from another hospital; skilled nursing facility; intermediate care facility; other health care facility; or patients with a diagnosis of ESRD.

Source: claims data

What is the problem and what is known about it so far?

The lifelong risk of developing Congestive Heart Failure (CHF) is 20% for Americans over 40 years of age. Absolute mortality for CHF is about 50% within 5 years of diagnosis. CHF patients may have important co-morbid risk factors for Hypertension, Diabetes Mellitus, Metabolic Syndrome, Atherosclerotic Disease, but routine assessment and expedient treatment of these may forestall the onset. CHF is the leading cause of hospitalization in people older than 65. The cost of CHF care in the United States exceeds \$30 million annually, with over 50% of this cost due to hospitalization. Patients hospitalized for CHF are at a high risk for all-cause admissions, at a 25% rate within one month. Despite advances in imaging technology, a careful history and physical examination remain the cornerstones in the assessment of patients.

Recommendations:

A: Diagnosis and Classification

Recommendation	Action	Collaboration/CHAC Approach
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Developed by Diane Leach with contributions by Bradley Berryhill, MD for Community Health Accountable Care, LLC (2015)
Approved by the CHAC Board on 04/15/2015

<i>Diagnosis</i>	<ul style="list-style-type: none"> • Idiopathic or Familial Dilated Cardiomyopathy (DCM) • LVEF <40% • Previous myocardial infarction • Patients may present with CHF symptoms, including: shortness of breath, Orthopnea, rapid weight gain, swelling in hands, feet, and legs, fatigue, dizziness, and chest pain • Complete H&P should be performed to verify: <ol style="list-style-type: none"> a) Tobacco Status b) Diet c) Co-Morbid Conditions d) Exercise Tolerance e) Health Status 	<ul style="list-style-type: none"> • Identify cohort population • Risk stratify individual patients • Schedule periodic ambulatory assessment encounters. • Educate patients/families. • Develop a CHF Self-Management and Action Plan.
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B: Disease Management

Recommendation	Action	Collaboration/CHAC Approach
<i>Step care for clinical need and disease severity</i>	<ul style="list-style-type: none"> • Non-pharmacological therapy (see Section C: Health Maintenance and Prevention) <p>Pharmacological recommendations include:</p> <ul style="list-style-type: none"> • ACE Inhibitor, Diuretic, Digoxin, CoQ-10, and to avoid “sleep medications” • If ACE inhibitor is not tolerated, consider hydralazine and isosorbide dinitrate <p>If symptoms persist:</p> <ul style="list-style-type: none"> • Persisting fluid retention: consider combination of oral diuretics such as loop diuretic with: thiazide or metolazone, spironolactone, or an intravenous diuretic • No fluid retention: consider digoxin • Identify and treat co-morbidities independently 	<ul style="list-style-type: none"> • Educate patient/family. • Develop an individualized CHF Self-Management and Action Plan. • Develop and implement a chronic care (CHF) checklist. • Risk stratification is protocolled. • Clinical risk reduction is structured into workflow. • Functional and durable Direct Access to clinical care is fundamental to managing patients with CHF. Access will be structured at the facility and systems level of responsibility. • Individualized Home Monitoring for selected and vulnerable patients. The frequency to be determined by disease state. • Home health services for monitoring of patient log and

	Referral Management: <ul style="list-style-type: none"> Consider appropriate referral to home health. Patient should have referral to Cardiology if AMI care is needed. If these recommendations do not work, patient may require hospital admission and additional treatment. 	early intervention per protocol.
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C: Health Maintenance and Prevention

Recommendation	Action	Collaboration/CHAC Approach
<i>Immunizations</i>	<ul style="list-style-type: none"> Provide influenza vaccine annually to all patients with CHF or who smoke. Provide PCV-23 to all patients with CHF or who smoke. 	<ul style="list-style-type: none"> Educate patient/family Implement CHF Self-Management and Action Plan. Assess immunization status at <u>every clinical encounter</u>. Host flu shot clinics.
<i>Diet</i> <ul style="list-style-type: none"> Decreases water retention Improves activity capacity and quality of life experience 	<ul style="list-style-type: none"> Low sodium Low fat Avoid alcohol 	<ul style="list-style-type: none"> Educate patient/family to benefits of exercise and lifestyle modification. Referral to Dietitian
<i>Treatment of other co-morbid conditions</i> <ul style="list-style-type: none"> Reduces onset of CHF 	<ul style="list-style-type: none"> Screen and treat for Hypertension, Diabetes Mellitus, Metabolic Syndrome, Atherosclerotic Disease. 	
<i>Tobacco Cessation</i>	<ul style="list-style-type: none"> Inquiry at every clinical encounter. Medical intervention offered at every clinical encounter. 	<ul style="list-style-type: none"> Patient/family education. Refer to Vermont Quit Line and local resource. Consider referral to Community Health Team (CHT).
<i>Exercise</i> <ul style="list-style-type: none"> Improves symptoms Improves activity capacity and quality of 	<ul style="list-style-type: none"> Recommend walking or other exercise regimen daily. 	<ul style="list-style-type: none"> Educate patient/family to benefits of exercise and lifestyle modification.

life experience		
<i>Self-Management Plan</i> Educate patient to the benefits of risk modification and emphasize importance of <u>early interventions</u>	<ul style="list-style-type: none"> Develop and review a chronic disease Self-Management Program. 	<ul style="list-style-type: none"> Implement/utilize CHF Action Plan Ensure and test reliability for <u>Direct Access</u> at time of clinical need.

D. Transitions Management and Care Coordination

Care Transition is a vital, complex and multiple responsibility function. Patients with CHF are typically medically complex and multi-morbid, and therefore are best managed in a multi-disciplinary care environment which can be susceptible to fragmentation. This cohort is particularly vulnerable at the time of care transition and medical hand-off. Unstructured transitions can increase risks for avoidable suffering, unnecessary duplicity, medical error and higher costs. Effective communication across the continuum of care is fundamental to meeting Triple Aim goals.

Transition programming should be structured and powered to optimize patient and family experience within the context of a safe and high-quality care environment. To meet this goal, care at the time of transition should be organized with an understanding of the three domains of care coordination outlined by the National Quality Forum (NQF). These domains include:

- A Patient-Centered Care Plan which provides for the transfer of meaningful information such as clinical detail, medical record, reconciled problem and medication lists, and a plan of care; as well as sensibility for patient and family values, preferences, wishes and needs.
- Care plan execution within the context of a conceptual Health Neighborhood; for which primary care providers serve the important dual and parallel function of care coordination and medical oversight.
- Established clinical outcome goals.

E: Palliative Care

The decision to employ a Palliative Care consultation should be made from a Shared Decision perspective. The consultation should receive input from the patient, family, clinician(s) and other important stakeholders. Thresholds and triggers for palliation are invariably individualized. As a guiding principle, a Palliative Care consultation can be considered at the moment clinical management goals evolve from one of disease management and modification into a goal more oriented toward symptom management and optimization of life experiences.

Patient-level palliative programming should adopt a primary focus and sensibility for the quality of life of the individual patient, their caregivers and their family's experience. This work includes:

- Patient and family centered care with clarification of clinical understanding, acknowledgement of values and the expectations of care.

- Attention and management of symptoms which indicate suffering such as shortness of breath, Orthopnea, rapid weight gain, swelling of hands/feet/legs, fatigue, dizziness/light headedness, chest pain, and/or depression.
- Implementation of a grief and bereavement management plan.

It is an expectation that patients enrolled in a Palliative Care Program to be managed within the framework of the six domains of quality health care outlined by the Institute of Medicine: safe, effective, timely, patient-centered, efficient and equitable care. Additionally, care for these patients should follow the general framework of palliative and end-of-life care domains (eight) forwarded by the National Quality Forum.

F. References

Yancy, C.W., Jessup, M., Bozkurt, B., et al. (2013) ACCF/AHA Guideline for the management of heart failure: A report of the American College of Cardiology Foundation task force on practice guidelines. *Circulation*, 128, e240-e327. doi: 10.1161/CIR.0b013e31829e8776. Retrieved from <http://circ.ahajournals.org/content/128/16/e240>

National Quality Forum. *NQF Endorsed Measures on Care Coordination*. December, 2014.

http://www.qualityforum.org/Publications/2014/12/NQF-Endorsed_Measures_for_Care_Coordination_Phase_3.aspx, accessed 2/10/2015.

National Quality Forum (NQF), *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*, Washington, DC: NQF; 2006,

http://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_PREFERRED_Practices_for_Palliative_and_Hospice_Care_Quality.aspx, accessed 2/10/2015

G. Resources and Tools

Caring for Your Heart: Living Well with Heart Failure (free booklets and tools), accessed 2/11/2015. Please contact Bi-State Primary Care Association for booklet modified to CHAC's recommendations.

Depression Care Screening and Follow-Up

Reviewed and approved by CHAC Clinical Committee on 01.29.2016

Depression Screening and Follow-up Plan (Medicare, Medicaid, Commercial)

Two Part Numerator =

**1) Screening for depression using a standardized tool
(Eg. PHQ 2, PHQ 9, PHQ-A, BDI, CES, EDPS, GDS)**

AND

2) If positive, a follow-up plan documented on the same date

Follow-up = suicide risk assessment, pharmacological intervention and/or referral to a professional qualified to dx and treat depression

Denominator = Age ≥ 12 with one encounter during 2015

Exclusion:

Medical reason: Active dx of depression, bipolar, OR patient in emergency situation OR cognitively impaired (e.g. delirium)

If excluding because of dx of depression, dx must be prior to the 1st day of the measurement period

Patient reason: documented refusal

Source = medical record review.

What is the problem and what is known about it so far?

Depression is relatively common in primary care patients but is not always identified by primary care providers. Depression and other common mental disorders are frequent, disabling, and associated with high health care costs and substantial losses in productivity, yet only about 25% of patients with these disorders receive effective care. In a 2012 CDC report, 19% of Vermont high school children (grades 9-12) reported feeling sad or hopeless almost every day for two or more consecutive weeks (causing them to stop doing some usual activities during the 12 months before the survey was done), and 8% reported experiencing an episode of major depression in the 12 preceding months. More than one in five (22%) Vermont adults report ever being told they have a depressive disorder, significantly higher than the 18% among U.S. adults.

Persons between ages 18 and 25 have higher rates of reporting depression with an annual prevalence of 8.7%, while persons between ages 26 and 49 are slightly lower at 7.6%. Women have a higher rate (8.1%) than men (5.1%). Elderly individuals (65 years of age and older) have a slightly lower overall rate, but a higher percentage have other chronic health conditions which increases the risk of depression. This group also has the highest percentage of severe depression compared to any other age group. A 12 month study of dual-eligible, Medicare only, and Medicaid only persons ages 65 and older indicated a diagnosed prevalence was 19.4% for any behavioral health disorder (BHD). The most common was major depression, other depression and alcohol abuse or dependence. Dually-eligible patients had a considerably higher diagnosed prevalence of any BHD

(38.8%), compared with 16.1% in the Medicare only group. For women who are pregnant and postpartum the greatest risk of major or minor depression is at month two and three post-partum; however, the first trimester is also a higher risk time period for a positive depression screen. Rates of postpartum depression average 13%. Other groups at higher risk for developing depression include those with chronic illnesses (e.g., cancer, cardiovascular disease), other mental health disorders (including substance misuse), and those with a family history of psychiatric disorders.

Who should be screened?

All persons ages 18 and older should be screened annually. (The PHQ2/9 screening is also validated for use for children ages 12-17.) Persons who have a previous history of major depression are at a higher risk for subsequent depressive episodes. The PHQ 9 may be used to track improvement for persons with depression. Women who are pregnant or postpartum should be screened early in the first trimester, and a particular at-risk time is two to three months past delivery. Elderly individuals who have been hospitalized and/or have a chronic health condition should also be given consideration for post discharge screening. All individuals who also have a substance use condition should be considered to be at higher risk and may be screened more frequently than annually.

While all patients should be screened annually, those reporting sadness, a lack of interest or enjoyment in activities, decreased energy, insomnia, weight changes, feelings of loss and worthlessness, and recurrent thoughts of death or suicide should be followed closely.

Recommendations:

During the visit:

- Administer PHQ2 annually.
- Patient can fill out before exam and Medical Assistant or RN could score.

If the results of the PHQ2 screening are positive:

- Administer PHQ9, EPDS for perinatal women, or other screening for all patients

Follow-up care can include:

- Providers should have a referral process in place for patients who may be identified as needing depression care and are beyond the resource of that office (see PHQ Process for Referral and Follow-Up (Sample) in References and Tools).
- Refer or discuss diagnosis and evaluation, which should be made with use of screening tools and criteria DSM V 296.xx/300.4 and ICD -10 F 32.00 – F 34.1. See CHAC's Treatment Recommendations for further management advice.
- For patients with mild-moderate depression (total score of 10 or less on PHQ 9): Education and referral to support and education are recommended

- For patients with moderate to severe depression (10 > on PHQ 9): Referral for thorough assessment and pharmacological and/or individual or group therapy is suggested.
- For patients who answer positively on question 9 regarding thoughts of death or self harm: Immediate referral for assessment is recommended.

Other activities:

- Educate patients/families.
- Develop a Depression Self-Management and Action Plan. WRAP planning is an evidenced-based tool which can be used for persons with depression.

References

National Institute of Mental Health - Major Depression with Severe Impairment among Adults

<http://www.nimh.nih.gov/health/statistics/prevalence/major-depression-with-severe-impairment-among-adults.shtml>

RTI-University of North Carolina Evidence-based Practice Center; Research Triangle Park, North Carolina
Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes Evidence Report/Technology
Assessment Number 119 <http://archive.ahrq.gov/downloads/pub/evidence/pdf/peridepr/peridepr.pdf>

Lin WC1, Zhang J, Leung GY, Clark RE. Twelve-month diagnosed prevalence of behavioral health disorders among elderly medicare and medicaid members. *Am J Geriatr Psychiatry*. 2011 Nov;19(11):970-9. doi: 10.1097/JGP.0b013e3182011b66

Jürgen Unützer, MD, MPH, University of Washington; Henry Harbin, MD, Health Care Consultant and former CEO of Magellan Health Services; Michael Schoenbaum, PhD, National Institute of Mental Health; and Benjamin Druss, MD, MPH, Emory University *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes* <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf>

Kaiser Permanente Research Affiliates Evidence-based Practice Center *Evidence Synthesis Number 128 Screening for Depression in Adults: An Updated Systematic Evidence Review for the U.S. Preventive Services Task Force* AHRQ Publication No. 14-05208-EF-1 July 2015.

To find this document, go to the webpage below; go to supporting Documents on the right side of the page and select Final Evidence Review for the July 2015 reference above.

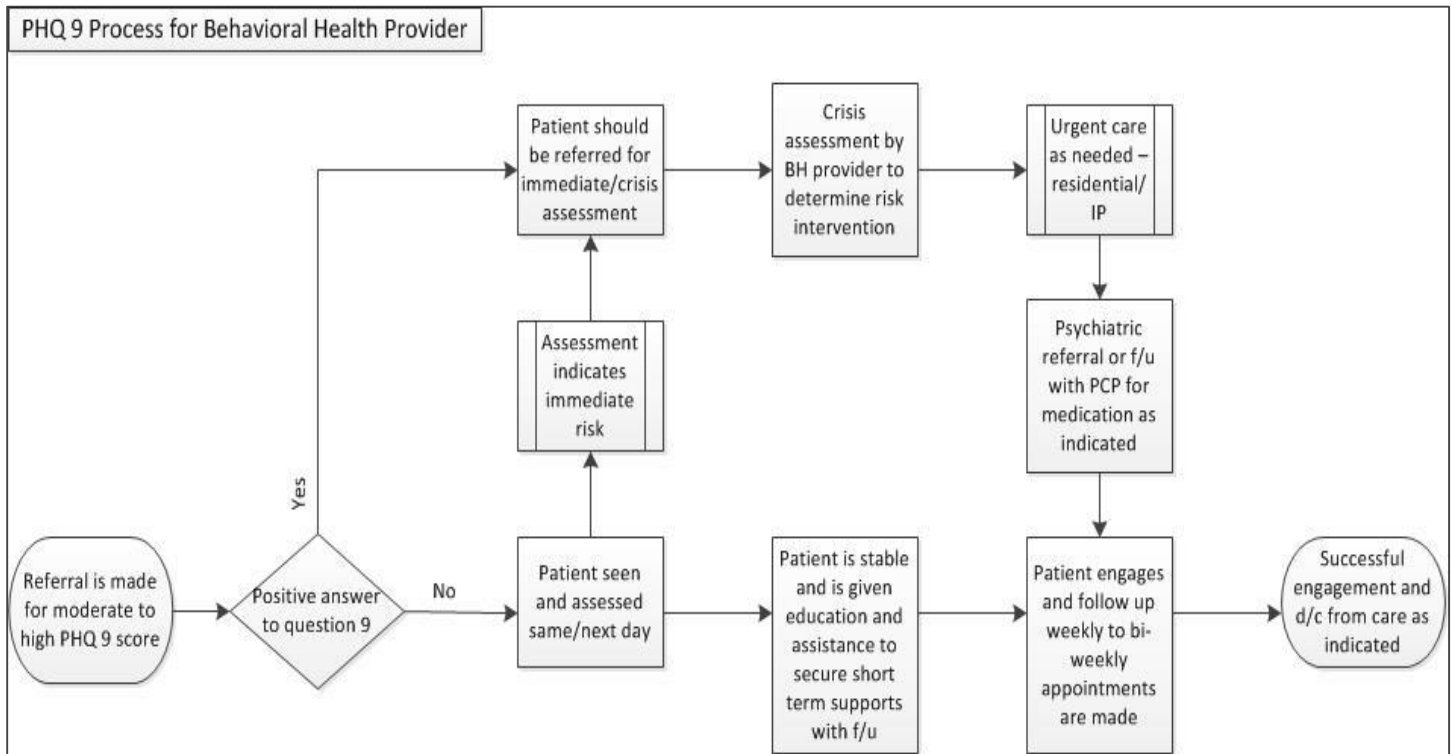
<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening?ds=1&s=depression>

Vermont Department of Health – Public Health Statistics 2014 BRFSS Report October 2015
http://healthvermont.gov/research/brfss/documents/summary_brfss_2014.pdf

Metzger, Jane. Preventing hospital readmissions: The first test case for continuity of care. CSC's Global Institute for Emerging Healthcare Practices.
(http://assets1.csc.com/health_services/downloads/CSC_Preventing_Hospital_Readmission.pdf) Accessed August 8, 2012.

Resources and Tools

- 1) Edinburgh Postnatal Depression Scale (EPDS)
<http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>
- 2) PHQ 2/9 <http://img.medscape.com/pi/emed/ckb/psychiatry/79926-1889862-1859039-2128912.pdf>
- 3) PHQ Scoring <http://emedicine.medscape.com/article/1859039-overview#a4>
- 4) Hamilton Rating Scale for Depression (HAM D)
<http://img.medscape.com/pi/emed/ckb/psychiatry/79926-1889862-1859039-2124408.pdf>
- 5) Patient Educational Materials - <http://www.nimh.nih.gov/health/publications/depression-listing.shtml>
- 6) PHQ Process for Referral and Follow-Up (Sample)



Diabetes

Reviewed and approved by CHAC Clinical Committee on 03.31.2015

Diabetes Composite (All or Nothing Scoring)

Numerators:

Patients who have received a retinal or dilated eye exam during the measurement year or a negative retinal or dilated eye exam in the year prior to the measurement year; and
Patients with most recent HbA1c $\geq 9.0\%$ or no A1c drawn/result missing
Lab test must have been done in 2014

Denominator:

Age 18-75 with an active dx of type 1 or 2 diabetes

Exclusions:

Patients with a diagnosis of polycystic ovary disease; gestational diabetes; or a diagnosis of secondary diabetes due to another condition

Source: medical record review

What is the problem and what is known about it so far?

In the United States, 21 million people have a diagnosis of diabetes. Greater than 90 percent of this population has been diagnosed as having Type 2 diabetes. An additional 86 million people have pre-diabetes, putting them at high risk for developing diabetes. Tight control of blood glucose, blood pressure, and lipid levels combined with Mediterranean or DASH diet and regular physical activity are proven interventions that may prevent the progression to a diagnosis of diabetes.ⁱ

Patients at risk for diabetes include:

- age > 45
- BMI > 25
- family history of diabetes
- member of a high risk population
- history of gestational diabetes
- physical inactivity
- hypertension

Recommendations for Provider Teams:

Identify People with Undiagnosed Diabetes and Prediabetes

Provide Ongoing Self-Management Support for people with a diagnosis of, or who are at risk for developing, diabetes

Provide Individualized Nutrition Therapy for people with a diagnosis of, or who are at risk for developing, diabetes

Encourage Regular Physical Activity for people with a diagnosis of, or who are at risk for developing, diabetes

Monitor Blood Pressure (every visit): B/P < 140/90

Monitor Blood Glucose (every 3 months if not at goal; every 6 months if at goal): A1c < 7

Monitor Cholesterol (at time of first diagnosis, at initial medical evaluation and/or at age 40, at periodic intervals thereafter)ⁱⁱ: LDL < 100mg/dL

Screen for Tobacco Use (annually)

Perform Foot Exam (annually)

Refer for Dilated Eye Exam (annually)

Administer Flu vaccine (annually)

Administer Pneumonia vaccine (at time of diagnosis and/or at age 65)

Prescribe anti-platelet therapy (ADA does not recommend except as a secondary prevention strategy in those with diabetes and a history of CVD)

- low-dose aspirin dailyⁱⁱⁱ

Recommendations for Patients:

Action steps for patients with diabetes:

- reduce portion sizes
- move more each day (aiming for 30 minutes a day)
- make healthy food choices (choose healthy carbohydrates such as fruit, vegetables, whole grains)
- take medications as prescribed
- check blood sugars regularly

Resources and Tools:

University of Vermont: Office of Primary Care and Area Health Education Centers (AHEC) Program. Vermont Academic Detailing Program (www.vtad.org)–Diabetes:

<http://www.uvm.edu/medicine/ahec/?Page=PatientResourcesandHandouts.html>

Vermont Department of Health. Diabetes Prevention and Control:

<http://healthvermont.gov/prevent/diabetes/diabetes.aspx>

American Diabetes Association. Standards of Medical Care in Diabetes-2015:

http://professional.diabetes.org/admin/UserFiles/0%20-%20Sean/Documents/January%20Supplement%20Combined_Final.pdf

ⁱ National Diabetes Education Program. *Guiding Principles for the Care of People With or at Risk for Diabetes*. Retrieved from <http://ndep.nih.gov/hcp-businesses-and-schools/guiding-principles/> on December 17, 2014.

ⁱⁱ American Diabetes Association. *Standards of Medical Care in Diabetes-2015*. pps 53. Retrieved from http://professional.diabetes.org/admin/UserFiles/0%20-%20Sean/Documents/January%20Supplement%20Combined_Final.pdf on February 26, 2015

ⁱⁱⁱ American Heart Association. *Aspirin and Heart Disease*. Retrieved from http://www.heart.org/HEARTORG/Conditions/HeartAttack/PreventionTreatmentofHeartAttack/Aspirin-and-Heart-Disease_UCM_321714_Article.jsp on February 26, 2015.